MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Princeton Pain Management 3710 Rawlins, Ste. 1400 Dallas, TX 75219	MDR Tracking No.: M4-03-7503-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Hartford Insurance Co. Box 27	Date of Injury: Employer's Name: Insurance Carrier's No.: YBUC 04918

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/25/02	**10/25/02**	**97750 (8 units)**	**$344.00**	**$344.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated May 30, 2003 states in part, "…For date of service 10/25/02, we billed the carrier THREE times for the PPE evaluation (97750) and to date we have not received a response from them…"

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not submit a response to the Request for Dispute Resolution. A copy of the Request for Medical Dispute Resolution was received by the carrier representative on June 17, 2003; the carrier representative received a copy of the additional information on July 14, 2003.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97750 (8 units) for date of service 10/25/02. EOBs were not submitted by either party. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of the carrier receipt of the providers request for an EOB. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(E)(2)(b)(ii) reimbursement in the amount of $344.00 ($43.00 x 8) is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
10/25/2002	97750	$344.00	$344.00				
				Total Left Column:			$344.00
				Total Amount Due:			$344.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $344.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	01-13-05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____